STATE OF MICHIGAN
OFFICE OF STATE EMPLOYER

ATTENDING PHYSICIAN'S STATEMENT

Please complete immediately and provide to the State's LTD third-party administrator, CORE, INC, 200 Wheeler Road - 5th Floor; Burlington, MA 01803
Phone 800-652-0025 Fax 781-270-8690

Patient Information

Name:_____ Social Security #:_____ Medical Record # _____
(First Name / Middle Name / Last Name)

Address:_____
(Street # / Street / City / State / Zip)

Current Department: Agency:

I hereby authorize any agency of the State of Michigan, insurance company, prepayment organization, employer, hospital, or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I certify that the information furnished by me in support of this claim is true and correct.

Date_____ Employee's Signature _____

History

When did symptoms first appear or accident happen? Mo._____ Day _____ Year _____

Date doctor authorized patient to cease work because of disability? Mo._____ Day _____ Year _____

Has patient ever had same or similar condition? ❑ Yes ❑ No

If yes, state when and describe

Present Condition

Subjective symptoms _____

Is the condition due to injury or sickness arising out of the patient's employment? ❑ Yes ❑ No If "yes" please explain. _____

_____

Objective findings. (Include results of current X-rays, EKGs or any other special tests). _____

_____

Is patient…Ambulatory? ❑ Bed Confined? ❑ House Confined? ❑ Hospital Confined? ❑ Contagious? ❑ On Narcotic Medication? ❑

Restrictions /limitations

Diagnosis

Diagnosis _____ ICD 9 _____

Name Of Hospital _____ Anticipated Length of Hospitalization _____

Surgical Procedure _____ Date of Surgery _____

If Pregnancy, date of LMC _____ EDC Date _____ Delivery Date _____

Treatment

Date of first visit for this **period** of disability Month _____ Day _____ Year _____

Frequency of visits ❑ Weekly ❑ Monthly ❑ Other _____

When did you last examine/treat the patient? Month _____ Day _____ Year _____

Date of next scheduled visit Month _____ Day _____ Year _____

Progress . . . . . Recovered ❑ Improved ❑ Unimproved ❑ Retrogressed ❑

Extent Of Disability

	FOR ANY OCCUPATION	FOR USUAL OCCUPATION
Is patient now totally disabled?	❑ Yes ❑ No	❑ Yes ❑ No
If no, when was patient able to go to work?	Month ____ Day ____ Year ____	Month ____ Day ____ Year ____
If yes, when do you think patient will be able to resume any work?	Month ____ Day ____ Year ____	Month ____ Day ____ Year ____
	Never ❑	Never ❑

If yes, is patient a suitable candidate for a return to work program? ❑ Yes ❑ No If yes, please complete the appropriate return to work assessment form.

Is the patient competent to endorse the checks and direct the proceeds thereof? ❑ Yes ❑ No

Print Name _____ **Street Address**_____ **City or Town** _____**State** _____ **Zip Code**_____

Signature (Attending Physician/Mental/Health Provider) _____ **Date**_____**Degree**_____**Telephone Number** _____